Local Government Association

Shared Intelligence

Stick with it!

A review of the second year of the health and wellbeing improvement programme

February 2015

Review

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1. Introduction

Shared Intelligence (Si) was commissioned by the Local Government Association (LGA) to carry out a review of its Health and Wellbeing Improvement Programme (the Programme) in its second year. The review builds on the work we did last year in reviewing the first year of the Programme which culminated in our report Great Expectations.[1]

The purpose of this review is to do three things

- understand the impact of the Programme
- capture system learning
- make a significant contribution to the national body of knowledge on health and wellbeing boards (HWBs).

This final report draws together our conclusions from across the three objectives. It updates our December interim report which primarily addressed the first objective – understanding the impact of the Programme – and draws on our separate presentation on the state of play of HWBs which was attached as an annex to the interim report.

In drawing our conclusions for this report we have reflected on the Programme in its entirety. However some aspects of the Programme were not included in the brief for this work. These included:

- the mentoring programme for board chairs which at the time of scoping this review had not started
- the various online tools including the revised self assessment and knowledge hub which had been reviewed in the first year evaluation and it was agreed with the LGA that another review so soon after this was unlikely to add anything new at this point.

This report sets out:

- a short summary of the context and our methodology (section 2)
- our findings on the impact of the Programme (section 3)
- our findings on the state of play of HWBs (section 4)
- our overall conclusions and thoughts on the future focus of the Programme (section 5).

1 http://www.local.gov.uk/documents/10180/11493/Great+expectations+-+A+review+of+the+Health+and+Wellbeing+System+Improvement+Programme/d8c4b00e-c3fc-4598-9e87-e5a719df2274

2. Context and methodology

HWBs are now near the end of their second proper year. Their introduction – signalled in the Health and Social Care Act 2012 – came with significant national expectations about how they would lead the transformation of health and care services locally and signal new locally driven ways of collaborative working across health and local government at a time when the financial and performance pressures on the health and care system are intense.

In recognition of these expectations, the Department of Health grant funded the LGA to develop a Health and Wellbeing Improvement Programme designed in collaboration with a number of partners including the Department of Health, NHS England, Public Health England and the NHS Confederation. The Programme was designed to cover health and wellbeing boards, public health and local healthwatch.

Following a widely perceived successful first year in which we concluded that the support offer was well received across the system, notably in local government, the Programme secured funding for a second year. Alongside this health and wellbeing support the LGA also leads or facilitates other sector led improvement programmes which have some overlap ie Towards Excellence in Adult Social Care and Integration (TEASC) and Better Care Fund (BCF) and all three of the programmes now form part of a wider integrated support offer across health and care. Our brief was to focus on the Health and Wellbeing Improvement Programme alone.

In our first year evaluation we concluded that the shape of any future support should explore:

- whether the highly regarded peer challenges should be supplemented with a new less resource intensive peer process which would enable more places to benefit from the challenge offered by peers over the next two to three years
- offering more priority to places most in need of support, with a bespoke menu of support
- strengthening the regional offer and giving it an explict remit to identify places in particular need of support
- the provision of support for HWB chairs for example through mentoring and leadership training
- support for boards which are struggling with the task of defining their purpose, roles and ways of working.

In setting the priorities for the second year of the Programme these recommendations were taken into consideration. In its second year the Programme has three top priorities:

- to support board leadership
- to strengthen regional partnerships
- to provide some capacity for bespoke support.

The main elements of the Programme to deliver these priorities are set out in the box below.

The Health and Wellbeing Improvement Programme – Year two

Health and wellbeing peer challenges (including peer training and action learning sets) – 20 in total for 2014/15*

Support allocated to regional partnerships for localised support *

Leadership essentials two day residential course offering leadership training for board chairs and vice chairs - x three courses planned for 2014/15 covering around 50 chairs and vice chairs*

Mentoring programme for board chairs using LGA peers

Bespoke peer support for individual boards *

National post to coordinate support to local Healthwatch, focusing on their role on the HWB and regional commissioning networks*

Revised self assessment tool and other learning shared using the LGA's website, Knowledge Hub, social media, direct correspondence and national learning events

*Included in scope of review

We have been mindful of these priorities and our conclusions from last year in reviewing the impact of the Programme and in drawing conclusions for the future.

Our work programme

In order to inform our findings we have:

- Reviewed the Programme's second year documentation including the revised prospectus, monthly board bulletins and feedback questionnaires from Leadership Essentials and healthwatch events.
- Interviewed six key stakeholders from Healthwatch England, NHS England, Department of Health, the Association of the Directors of Public Health, the Chair of the LGA's Community and Wellbeing Board, and a contributor to the Programme who is also a Chair of a HWB. Two of the six were interviewed as part of the first year evaluation, four were new interviewees this year.
- Undertaken six detailed peer challenge case studies involving a review of the feedback presentation and final report, interviews with the peer challenge managers and interviews with between three to four stakeholders from the places including the chairs of the board and the Director of Public Health for all, and a mix of representatives from the Clinical Commissioning Groups (CCGs) and others as nominated by the board.
- Carried out a detailed analysis of the documentation from a further five peer challenges.
- Carried out interviews in two regions (the North West and West Midlands) with the lead chief executive and/or the LGA regional lead.
- Conducted phone interviews with 16 board chairs and vice-chairs from the cohort of 35 who participated in the June and October Leadership Essentials course.

- Conducted interviews with the LGA leads for four boards which have received bespoke work and phone interviews with two recipients of that work from within the councils.
- Interviewed the LGA's local Healthwatch national coordinator and conducted a focus group with local healthwatch chairs.
- Conducted phone interviews with two mentees and two mentors as part of the local Healthwatch mentor programme.
- Conducted phone interviews with the facilitator and one action learning set of healthwatch representatives as part of the local Healthwatch programme.
- Facilitated a workshop with a range of stakeholders to test emerging findings and so explore how the national programme could support those most in need of support and help all move beyond competence.
- Held conversations with the Programme Manager and Programme Director to test and challenge emerging findings.

3. Our Programme findings

The overarching goals of the Programme – in shorthand to ensure that HWBs are confident in their system wide strategic leadership role, have the capability to deliver transformational change and to create improvements in the health and wellbeing of the local community – offer the broad context within which the Programme needs to deliver and continue to underpin thinking on the future direction of the Programme and the development of the Programme tools. We have been mindful of both this broad context and the revised priorities in conducting our review.

However, as time has moved on, and in the Programme's second year, before moving into a third, we felt it also important to to get a sense of the principles and features (starting with those originally articulated in the memorandum of understanding (MoU)) which stakeholders feel remain - or had emerged - of critical importance now.

The existing key principles as established in the MoU are set out in the table below.

Core principles of the Programme
Universal offer focussed on improvement
Regular and effective communications and engagement opportunities
Effective signposting to appropriate support and resources
Learning and experiences gathered from local areas, shared nationally
Building on what is done regionally and locally and use existing mechanisms and networks to disseminate learning
Support delivered at the most appropriate level, whether nationally, regionally or locally
Ongoing evaluation of the programme
A method for proactively identifying areas in need
A method for assuring the system is working
Tailored support provided to local areas and regions based on their specific needs
Those in greatest need identified and offered bespoke support

These principles can be broadly summarised into three key categories which from our analysis all still feel relevant and appropriate today. These are:

- ensuring a **universal offer of improvement** but critically:
  - one which is tailored to local need as appropriate
  - one which is delivered at the most appropriate level be that national, regional or local
  - one which ensures those in greatest need are identified and offered bespoke support.
- effective **collating, sharing and dissemination of learning** to ensure that the wider system benefits – making use of evaluations, national, regional and local networks, regular communications
- **ongoing evaluation** of whether the Programme is working including being responsive to outputs.

However during our discussions we identified some core features which stood out as being of critical importance now, some explicit within this original set, some simply more strongly articulated and some new. These are set out below.

Core features of the Programme emerging this year
Ongoing desire to see the Programme identify and support those areas most in need
The need for the Programme to support local system wide learning and have an impact beyond individual boards
The need for the Programme to consider how it should support boards beyond competence
The wish for the system to be responsive and fleet of foot in meeting demand within the system

We say a little more about each of these points below.

Bespoke support

The Programme's ability to identify, support and manage the risk of boards struggling to deliver and to be able to direct support to these boards is clearly a primary concern, particularly of some national stakeholders. This is perhaps ever more evident this year due to the noise in some parts of the system as a result of the BCF process. Not withstanding the reasonable outcomes of this process, the draft plans had flagged initial concerns about the scale of the boards'ambitions and capacity to deliver and to adequately engage acute providers in the system in doing this.

In addition, while all national political parties have offered a sense of ongoing support for HWBs, there is a general recognition that if HWBs are to take on additional responsibilities they need to further develop their capacity. It is also probable that a future government will be more skeptical of impact and success of sector led improvement programmes in bringing about improvements without a clear focus.

The new bespoke support element of the Programme this year has been designed at least in part to help address this issue. The available resource (around £100,000) was at a practical level combined with the monies available to help address support requirements for the BCF. While there has been some progress with a small number of boards receiving tailored and (as far as we have been able to determine at this relatively early stage) effective support, much of the support has been directed specifically at getting boards BCF 'match fit'.

Our review of the bespoke work has been limited in scope due to the relatively small numbers of places receiving the support (we understand maybe around 10 – excluding BCF support – this year) but what we have seen has raised more questions than answers.

It remains too soon to determine with any authority the impact of the bespoke work (though from early discussions the work has been well received and if the BCF support can be judged by outcomes of the BCF process then in part successful). But what is more apparent is that expectations on how places are identified for bespoke work and why, the type of support they should receive, from whom and how impact is then assessed is not shared across stakeholders and participants.

By its nature this work is often inherently sensitive and confidential and there is sufficient pragmatism in the system to recognise this and the challenges to a rigid structure this brings. However, in our interim report we concluded that the lack of real clarity across key stakeholders in the Programme about ambition and delivery is stark.

The LGA recognises this and in order to secure some shared understanding on this for future years we facilitated a workshop designed to allow us to explore and conclude these issues in more detail.

It was recognised in this session that being able to identify and support those most in need is an inherent challenge for all sector led improvement programmes, not just this one. It is well understood that those most in need are often probably those who are least aware of this need and who are least likely to volunteer to engage with universal offers such as peer challenge and leadership courses or bespoke programmes.

Given this, one of the first conclusions we drew from the session was that there needs to be a systematic way of identifying these places and needs which draws on a number of different sources of intelligence including:

- which places are engaging or not engaging with the programme and more widely
- local contextual information around risks eg extreme financial pressures, challenging health economy, performance issues of local stakeholders etc
- pressure points such as political change and/or change in board leadership
- possible national 'proxies' for whether local systems are coping such as progress on BCF processes (though people expressed concerns that any interpretation of these must be placed into wider context)
- local knowledge.

The LGA already has a well established set of structures and processes driven by its Improvement and Innovation Board which captures information on needs and risks in the wider system. Therefore it is not the case that this type of intelligence is not captured already, but more that it needs to happen more systematically for the health and wellbeing system in order to inform the future focus and targeting of this element (and others) of the Programme.

The second important conclusion which emerged from the discussions is that the LGA sees the primary focus of this work as not about the small number of places with significant support needs but rather the wider cohort of those who, in now perhaps old fashioned improvement speak, are 'coasting' and need support/impetus to move forwards and to avoid slipping back. This is based on the belief that the former smaller cohort are already 'known' in the system, the larger 'coasting' cohort are not. The consensus reached in the discussion seemed to accept this on the condition that the former smaller cohort are appropriately supported as well.

Thirdly it was concluded that the real challenge in this arena is not first and foremost the identification of places most in need of support, but 'getting in the door' and getting sign up to participation. Two features emerged as important in getting to this position – the first is identifying someone 'whose job it is' to understand the local issues and needs and to powerfully articulate the benefits of any support offer, and the second is ensuring greater clarity of what elements the offer more generally might include.

The final connected piece here relates to the regional element of the Programme. In our report last year we concluded that the regional element should be better funded with lead chief executives and their colleagues given an explict remit to identify areas most in need of support. An additional £150,000 was allocated to regional groupings this year (so an increase of around 50 per cent on the previous year's allocation). Some regions have combined this money with other national support monies such as TEASC monies to create a relatively significant pot.

The commitment to the importance of collaboration at a regional or sub-regional level from lead chief executives and health colleagues remains and this is evident through the existence of regional working, events and networks and the BCF activity. In addition the regional chief executives all played a key role this year in managing the risk of meeting the BCF processes and expectations.

However our review of the regional element this year has confirmed that the regions still do not have the remit, capacity nor infrastructure to identify and work with those areas most in need of support on the broader agenda and in our interim report we concluded that it might be timely now to review expectations of the regional element of the national programme and the implications for resource and governance.

These issues were considered at the workshop we refer to before. There was an emerging consensus that the regional networks which exist are now established. These networks are variable with some more established and proactive than others. In some places it was accepted that other groupings such as core cities or county groupings are as or more relevant . There was no strong sense that more investment towards regional networks would add further value than currently exists and, given that, it was deemed sensible to explore other avenues.

There was support in the workshop for the LGA's proposal to invest Programme resource (and more of it than currently) to enhance the role, capacity and remit of an Improvement Advisor role – a model which already exists as part of the TEASC programme. This fits with the importance referred to before of making it someone's job to understand local needs and dynamics. We understand that the LGA is currently developing this proposal.

Influencing the wider system

We believe that there are two distinct points being made by stakeholders here. The first more prosaic point is that the Programme needs to encompass all within the system, not just councils. The second bigger point is that the Programme's impact should be felt system wide not just on the individual boards receiving the support – hence in part the demand for the robust dissemination of learning.

The focus of the Programme has always been to support boards in their system leadership role. However, and perhaps inevitably because the boards are established within the councils as council commitees, there was some mild criticism last year that the Programme was too council centric. This year the Programme has looked to address this though a number of ways including notably:

- bringing the Programme under the auspices of a wider set of health and care support work with a subsequent broader audience for the work
- broadening the scope and work of the peer challenges to a wider range of stakeholders
- including Vice Chairs from CCG or other backgrounds within the Leadership Essentials scope
- broadening the support for local healthwatch beyond the role of local government as commissioners to encompass the role of local healthwatch representatives on the boards.

All of these steps have gone some way to broadening the scope of the Programme and this has been tangibly felt and appreciated by some national stakeholders. In addition, CCG representatives we spoke to have been very appreciative of this inclusivity and would welcome more opportunities to engage across sectors where possible. Similarly council representatives have hugely valued the clinical or broader perspective where received.

We have not looked across other national support programmes as part of this review but it would be worthwhile for the LGA and national partners to consider where further joining up of support and where invitations across sectors could be facilitated.

The second bigger point being made is about the Programme having a wider local systems impact and links to the 'beyond competence' points made below. In summary stakeholders are saying that in order for the Programme to have real impact then it must have a wider local systems impact which goes beyond individual boards and, at the same time, the Programme should help individual boards go 'beyond competence'. We would also conclude that the two are inter related: for boards to move beyond competence they themselves must have an impact on the wider local system.

By its nature as a national programme, the support offer is only going to be able to directly 'do' or 'intervene' so much. It is important therefore that the support 'interventions' are designed to encourage maximum impact which goes beyond individual boards and organisations to the wider local system. In a piece of work Si undertook for the LGA a while back on the evaluation challenge of leadership development (Leadership Development in Place: Meeting the Evaluation Challenge), we used the analogy of ripples in a pond to describe this set of complex interactions and this is largely relevant here also.

The essential idea is that an individual (in this case a board) participating in a programme is like a pebble being thrown into a pond.

The immediate ripples represent the impact of the programme on the individual (the board). The more distant ripples represent the impact of the programme beyond the individual (board) on the organisation (here the place) and the wider local system.

To do this wider system influencing well, the Programme needs a better understanding of the features which encourage boards to have a wider impact so the Programme can focus on encouraging and enabling these features. We have identified some of these features in our work on the state of play of boards and say more about this in the next section.

Beyond competence

The Programme is now in its second year, as are health and wellbeing boards. In the first year the boards were 'settling in', moving from boards in shadow form to real entities. A key emphasis of the Programme in the first year was on supporting this transition stage ie reviewing how the transfer of the public health function had taken place, reviewing how the commissioning of local Healthwatch was being enacted, helping the forming of the boards and their relationship building.

In the second year the focus has legitimately remained in part on the 'forming 'of the boards but with some real targeting of audience, so for example offering support to board chairs in their system leadership roles. The focus has moved towards challenging more around consolidating these developments and delivery, for example through refreshed scope of the peer challenges, the work around the BCF and the move from solely supporting the commissioning of the local healthwatch function to supporting the role local healthwatch representatives play on the boards.

So where next for the Programme? This was an issue spontaneously raised by some key stakeholders during our discussions. Some expressed a need for the Programme to offer challenge and support to move boards beyond competence towards excellence or at least be in the position to do so when the time was right.

These stakeholders saw this role as more challenging for programmes such as this one than the 'getting everyone up to speed' gear it was perceived to be in currently.

In the beyond competence discussion at the workshop referred to before we explored some of these issues further. The following observations were made:

- the methodology, notably that of the peer challenge, needs to be refreshed to ensure it encapsulates the features of a well performing board which have emerged in our review (refer section 4)
- the Programme needs to learn in real time from other initiatives such as the BCF support and activities
- there are some key issues which Boards still need support on or to refresh eg reviewing their strategies, understanding the different cultures of board members which the Programme should not ignore.

We return to this issue in the next section of the report.

Responsive and fleet of foot

During discussions with the LGA team, the Programme's capacity to be fleet of foot and responsive to current need in the system was highlighted as central to the Programme's effectiveness.

Key elements such as the peer challenges have always had an element of flexibility built into the process eg some capacity to consider additional issues specific to the local area beyond the core methodology. In addition the regional element, compratively small as it is, is flexed around local need and demand.

But the wish to ensure the Programme has some capacity to direct, switch or supplement support and resource to tackle a specific issue, set of issues or demands in year extends beyond local tailoring. It is founded on the sense that, given the still relative newness of the agenda, there will likely be unanticipated learning needs and demands that the Programme should be able to meet, and desire for the Programme to remain locally focused.

This is particularly the case in a system where the national context is changing, not least with the election later this year, and the local context is also susceptible to local change eg new chairs.

A good example of this responsiveness is the practical guide to good governance issued by the LGA under the auspices of the Programme this year, the additional Leadership Essentials course which has been scheduled due to high demand, and the extension of invited participants to include representatives beyond councils.

We return to these four features – managing and supporting underperformance, systems wide learning and impact, supporting boards beyond competence and the capacity to be flexible and responsive – in the concluding section of this report.

The following paragraphs report our findings and conclusions on the impact of the two bigger elements of the Programme, peer challenge and the leadership work, and the element of the Programme relating to local Healthwatch.

Peer challenge

The peer challenges remain the cornerstone of the Programme both in terms of scale of investment and their potential impact. Bespoke teams of practitioners and peers from across the system work on site with the board and its partners for four days.

Twenty peer challenges have been undertaken or are planned in 2014/15 (seventeen in 2013/14) and the resource committed to these represents a significant proportion of the overall pot. In addition there is considerable investment in peer training for those who undertake the peer challenges.

Feedback from our case studies demonstrates that the peer challenge process remains a highly respected one with demonstrable immediate impact.

All of those interviewees we asked directly said they would recommend it to others and for many the process offered both reassurance and validation of direction of travel on one hand and a necessary degree of challenge on the other.

For a few the impact had been a dramatic one with key action taken immediately. For example changing the membership or indeed leadership of the board and catalysing discussions on the big issues . For most, the process added welcome focus and real momentum and provided the boards with confidence on next steps. Interviewees reported that challenging feedback had been handled well and that the peer teams were capable, skilled and appropriately experienced. Of particular value were the one to one peer discussions between team members and their counterparts in the place being reviewed. In addition though still being sought, more people reported on being signposted to good practice elsewhere.

In addition it is notable that the demand for peer challenge is still outstripping supply and the ongoing richness of the data and learning produced from the peer challenges is evident. It is this rich system intelligence and learning that forms the basis for much of our state of play conclusions (refer section 4).

However, despite this overwhelming positive sense, there are some issues raised in our discussions around individual peer challenges which merit attention in any process refresh. These included:

- A sense that some of the challenges produced too many recommendations around priority next steps. Through our documentation review it is evident that the peer challenges summarise the top points for consideration to help with this focus but also include in the detail a number of points which lie beneath these. It is perhaps in marrying the two up that some felt became more overwhelming and this serves as a useful prompt to ensure key priorities and actions are filtered appropriately. The LGA has been aware of this and the more recent peer challenges have been streamlining priorities and recommendations accordingly.
- A sense from a few that the peer challenge team 'pulled their punches' in their final feedback and in doing so slightly missed having the total impact the thoroughness of the process deserved. In discussion the few individuals who raised this accepted that the real value of the process , and the way in which it gets traction and genuine buy in, often takes place in the informal feedback and discussions with those who really need to hear the messages.

In addition the same headline challenges to the overall process exists as we reported last year ie only a small number of places can benefit from the peer challenges in its current resource intensive format (about one-quarter or 37 places will have had a peer challenge over past the two years) and the resource demands the process places on both the individual team members and the place being reviewed are high. One or two clinicians we spoke to were keen to engage as peers in the process but held back due to the time commitment. Alongside this there continues to be a demand to capture and disseminate the considerable peer challenge learning in a systematic way.

Last year we raised the issue of peer 'snapshot', not to replace the existing process nor as a simple slimmed down model, but as a supplementary but separate process. We understand the LGA considered this but believed that the integrity of the peer challenge process as a strategic tool with 'teeth' available across the spectrum of board performance needed to be protected. The LGA was concerned that that a more streamlined peer process would lead to more service specific reviews and miss this bigger picture.

We understand that thinking here has moved on in this second year of peer challenges and the LGA is now considering a more streamlined sharper process – possibly of three days – which would go some way to addressing the resource issue and potentially buying in a wider cast of peers.

We understand that the LGA is keen to maintain the current more organic approach to peer challenge which means adopting a flexible structure and tools in the process to target local need and for many this is key to the peer challenges' success. However in discussions the LGA also recognises the need to refresh the peer challenge with the latest research intelligence and to reflect national expectations as appropriate.

An ongoing challenge for all sector led improvement models, not just this Programme, is to be able to demonstrate that they have 'teeth' and remain having them. This will likely be particularly important in the immediate post-election period. It is timely therefore to refresh the Programme's objectives and tools in this context.

Finally, in considering the impact of the peer challenge it is important to look at both the impact of the peer challenge on the individual board receiving the peer challenge and on the wider system. This goes directly to the feature of wider local system influencing referred to before.

Our review of the peer challenges demonstrated that there is plenty of evidence to show that the peer challenges sparked action by the boards receiving them for eg review of performance monitoring systems, away days to revisit priorities, creation of sub structures, change in personnel etc.

However it is probably still too early to conclude with confidence whether those actions had the intended effect or, in other words, achieved what had been anticipated when recommended. However early indications from two case studies we undertook to explore the longer term consequences of the peer challenge are that for one place the actions have contributed to an ongoing sense of focus and confidence as intended, for the other place the change in personnel has not yet created a stronger, better positioned board.

Leadership Essentials course

Beyond the considerable value the chairs of boards have expressed they receive from the peer challenges, the priority of the Programme to support board leadership is specifically addressed in two further ways: a Leadership Essentials course and mentoring for board chairs and vice chairs (latter outside scope of review).

Two Leadership Essentials courses held over two days have been run or will run this year (June and October) with a further session planned in the new year covering approximately 50 board chairs or vice chairs. The LGA's own feedback forms completed by participants on the day demonstrate that the courses have been well received.

As part of our review we interviewed sixteen participants from the first two courses (just under a half) and while predominantly council representatives we also spoke to some CCG reps as well. This reflected the make up of the course participants. The feedback we have received has reinforced that which was noted on the on the day assessments and has been overwhelmingly positive and supportive. No one we spoke to did not get some value from the course and most felt it had been invaluable in offering opportunities to share progress, challenges and solutions with peers.

Perhaps the most valued aspect of the course is also the simplest – the opportunity to network with others in a similar position and facing similar challenges but to do this in a way which focused on potential solutions. Some expressed the ability to do this away from their local 'geography' as being of particular value. The clinicians who attended were equally approving and they and one or two others also expressed a wish for there to be more mixing of health and local government.

Many cited the 'memo to self' (completed by participants and copies to be sent 6 months from the date of the course) as being helpful and looked forward to following this up. The immediate success of the course is perhaps summed up best by the comment from one influential council leader and board chair that they would attend again with a different cohort.

From this we are able to conclude that demand for this type of leadership support is there and the course was highly effective at meeting the expectations of those individuals who attended. It is too early to conclude about the wider impact on the participants' boards and beyond that to the whole system.

Local Healthwatch

A notable element of the Programme for two years has been its focus on supporting local Healthwatch. In the first year this support was broadly geared towards supporting local authority commissioners in establishing and commissioning their local Healthwatch. This year the focus has shifted along with the agenda and has focused on two particular aspects:

- continuing to support commissioning networks with a sense that they have or should become self supporting over time
- supporting the local Healthwatch representatives on the health and wellbeing boards to become more effective 'collective leaders'.

By clarifying the focus in this way the Programme is making a 'offer' which is distinct from Healthwatch England's role in supporting local Healthwatch more widely.

Key activities of the Programme include supporting regional commissioning networks, offering some limited bespoke support where there has been demand, and publishing a toolkit (Healthwatch: On the board) at a learning event.

The latter was specifically designed to raise awareness of the political environment of councils and boards, to offer opportunity to reflect on leadership styles and to think about what this means for being a 'collective leader' on the board. In addition the LGA has encouraged local Healthwatch chairs and chief officers to train as peers and for chairs to partcipate on leadership courses.

Our discussions with local Healthwatch representatives, board colleagues and stakeholders more widely suggest that local Healthwatch representatives on the Boards are recognised as having an important role but one which for most is very much in development currently. Some of the more proactive local Healthwatch representatives feel they are valued and that their role is now better understood both by themselves and others more clearly.

One or two more we spoke with feel they have real influence on the board but this does not feel typical of most. Our work as part of this review was fairly limited in scope but these conclusions are supported by some more detailed work we have done elsewhere. This work has also emphasised the limited capacity of the local Healthwatch chairs to engage despite goodwill to do so as often they undertake this role in an unpaid capacity alongside a 'day job'.

Given this, it is clear that the local Healthwatch chairs need to be supported in their roles and it feels right that the focus of the Programme's activity has been to support them distinctly in developing their leadership role and influence on HWBs. From the discussions we did have with local Healthwatch colleagues engaged in the learning event and the mentoring programmes feedback has been positive and the mentoring has clearly been a positive experience for the participants and one they would recommend on.

These positive signs suggest that mentoring and action learning sets are learning techniques which have a useful role to play looking ahead.

However individual mentoring is clearly a resource intensive option. Alongside this the LGA piloted two action learning sets. It is very early days in progress terms for these but it is already noticeable that take up and attendance has not been 100 per cent. Once again this may be more an issue about capacity to commit to the sessions rather than a lack of commitment.

It is worth noting that the timescales for the action learning sets (we understand the meetings were scheduled over a five to six month period and for the set we spoke to resulted in three one day long sessions) do not allow sufficient duration for the sets to be truly effective or self sustaining. From our experience you need at least six meetings of around six to eight weeks apart to see real results and to galvanise and build a group's self confidence. The LGA appreciates this and it is a consideration for any further roll out.

The LGA has encouraged local Healthwatch chairs to participate in the peer challenges as peer team members and has received positive feedback on early experiences here. We know from our review of the peer challenge process that the peer team members often express as much satisfaction and learning in carrying out the peer challenges as those who receive them. This feels like a really useful development and one which should be promoted further.

4. Health and wellbeing boards – current state of play

In drawing together our findings on the current state of play of health and wellbeing boards, which were largely informed by the peer challenge material and our discussions with board chairs, we concluded that there remains a spectrum of maturity and ambition of boards. The evidence suggests that most boards are addressing with variable success a range of challenges and issues and that given this it is not a straightforward picture of some boards doing everything well and others not. Indeed in discussions we have suggested that progress is best represented visually by a bell curve rather than a linear graph.

Having said that, there is widespread progress being made across some common themes. These include, for example:

- building relationships between board members
- using development sessions/ informal meetings to clarify focus, role and priorities
- developing sub structures and working groups to support the board – some operating within the direct ambit of the board, some not
- using the BCF to provide a focus for efforts.

We also believe that it is fair to say from the evidence that a smaller number of boards are ahead of the curve. The boards which have made better progress have looked beyond tackling the immediate 'problems' in the system and kept a disciplined focus on the bigger picture.

Some key steps these boards have taken include:

- having the difficult conversations about shifting money around
- keeping focused on the big picture beyond the BCF ie bringing attention back to the longer term health issues
- having real clarity on quick wins (some boards have developed first 100 day plans), short-medium terms gains in the first two to three years and the longer term
- maintaining a focus on both health and wellbeing and preventative and acute
- ensuring that all board members and their component organisations are bought into and acting upon board strategy.

However it is also evident from the review that many boards are still some way off driving the big issues and that progress is slower than perhaps widely anticipated. Frustrations exist within and outside of boards.

The evidence from the peer challenges and the board chair interviews points to the frustrations centring around a sense that the boards often lack 'teeth' (often linked to a real or perceived lack of ability to allocate resources) and clarity of their distinct added value ("need to say what we can do that only we can do"). Also many have still to position themselves as the key strategic forum for driving the agenda and are seen in a more enabling than leading role.

In addition, there are frustrations on both local and national sides that boards are not meeting expectations of progress more generally.

Locally board representatives have expressed concerns about workload "growing like topsy" and boards being seen as "cupboards to throw everything in". There is local recognition that boards need to keep focused on their priorities, not try to do everything and to move from strategising to influencing and taking action.

However, a strong sense also emerged that the increase in workload often links to national expectations and pressures. We referred to this 'mission creep' and the risks attached to letting the demands on boards grow in an unstructured way in our Great Expectations report last year and the need to manage those expectations and requirements of boards seems as relevant now.

Despite these frustrations, the uncertain context of the national election and any further "churn" this year, the mood music remains cautiously optimistic. Not one person we asked directly said they would choose to abolish the boards.

The BCF process, while not appreciated by all, has certainly catalysed progress and shone a light on strengths and pressure points.

The bigger sense was that many boards need to regroup and move beyond strategising and in doing so build ambition and capacity.

However the task of bringing together the many siloed agendas and organisations impacting on health and wellbeing and agreeing collective action was, most people we spoke to agreed, something that only health and wellbeing boards could do.

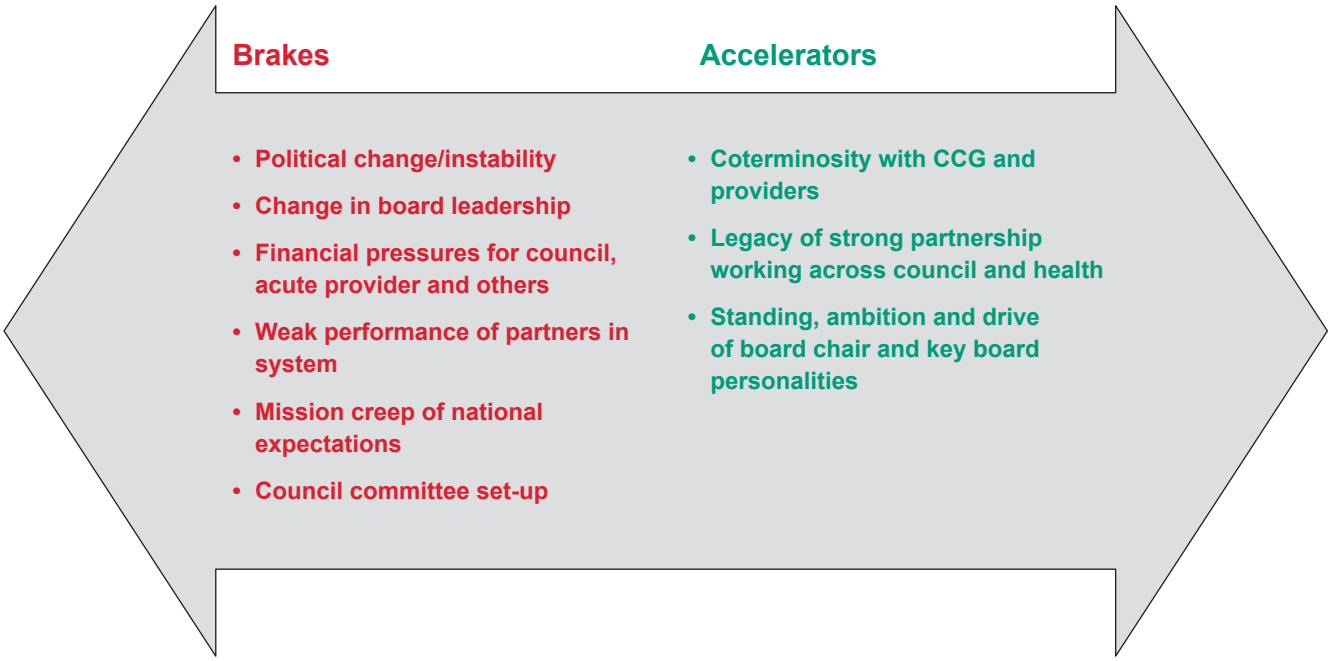
In our two reports last year we summed up our conclusions by the phrases 'Change gear' , 'Get a grip' and 'Great expectations'. This year we would sum up our conclusions with the phrase 'Stick with it!'.

What lies beneath

In this section we explore what lies beneath these headlines. In doing this we look at:

- areas still requiring attention
- the key features of a well performing board
- some discussion points about where the well performing board might go next to build on good performance, or in other words to move beyond competence.

First though it is worth noting that during our review it became apparent that there were a number of factors which were commonly cited as having an impact on boards' progress but which often sat outside of the boards' immediate control. These factors are illustrated below.



These contextual factors and their impact in helping or hindering progress should be understood. They represent, for example, legacy issues boards have inherited, challenges they face within the local health economy, or issues to do with political 'churn' in the system. Some of these are clearly perceived to accelerate progress – a commonly cited example here was coterminosity of the council with the CCG – while others were perceived to slow down progress, notably for example a change in political control and board leadership.

Having said that, our review suggests that many of the key challenges we identified in our report Great Expectations remain relevant today and it is fair to say that the solutions for many of these issues lie within the gift of the individual boards. We say more about these issues in the following paragraphs.

Areas requiring attention

From our review we have identified four areas still requiring attention by many boards. Evidence suggests that for some it is probably more about revisiting these steps or reinforcing the outcomes rather than starting afresh. These areas are:

- ensuring clarity of purpose of the board
- building a model of shared leadership within the board
- working with partners to develop the systems leadership role
- ensuring delivery and impact.

In the table below we set out key activities which typically fit under these four headings.

Areas requiring attention
Ensuring clarity of purpose
• establishing the board as the primary strategic forum for driving change • reviewing positioning in relation to wider partnership structures • sharpening priorities and agreeing big ticket items • ensuring alignment with other relevant strategies and plans
Building model of shared leadership within board
• developing skills and confidence of all board members • ensuring parity between board members – not about 'posturing' between health and local government, not a council 'piece of kit' • understanding each other's needs and constraints
Working with key partners to develop systems leadership role
• understanding what only the board as a collective can do, not its individual component parts • considering how to proactively engage providers and to be relevant to them • being ambitious and visible • recognising the board is not providing a scrutiny function
Ensuring delivery and impact
• ensuring board agenda focuses on the delivery of key priorities • establishing a set of focused action plans and performance measures • ensuring discipline to stick with priorities • making smarter use of data and evidence to monitor impact • maximising formal board meetings and making better use of time between board meetings • ensuring officer support structure is robust to support the board and drive performance

In our report Great Expectations last year we set out a number of questions Boards could usefully ask themselves in reviewing their work priorities, practices and structures.

Given the issues raised above, these questions remain largely relevant and we have attached them again as **Annex A** to this report for information.

Features of a well performing board

Despite the fact that for many boards there are a number of issues still needing attention, our review also identified a number of boards doing good things. From this work, we have been able to establish a developing picture of the key attributes of a well performing board. These are summarised in the table below.

A well performing board	
Key attributes	**Key actions**
Evident passion and ambition	Recognises the need for fundamental change to health and care system eg has ambtious BCF and plans for future
Enthusiasm, drive and leadership – notably but not solely from board chair	Has refreshed priorities which align clearly with council, CCG and other relevant plans
Demonstrates positive behaviours	Has developed a narrative and road map for change setting out how system can move from where it is now to where it needs to be and which can help staff, providers, partners and the community
Strong foundation of partnership working	Invests in new ways of working eg uses developmental sessions to develop trust and collaboration, operates as a board not a council committee
Trust, respect and genuine collaboration across board and with key external stakeholders	Has developed a coherent radical strategy which underpins an integrated approach to commissioning
	Uses a robust performance framework to plan future activities
Open to learning and challenge – self aware	Has pragmatic and effective approach to engagement of providers (for eg provider forums, provider engagement in sub structures, providers on board)
Committed to engaging with local people and communities	Through this has a shared understanding of the role of providers in delivering change
Shared understanding of how board fits with other structures eg scrutiny	Ensures effective engagement with the public is everyone's business and local healthwatch is building on networks to increase engagement and visibility

This list is not intended to be exhaustive, but rather a starting position which will evolve as the agenda develops, boards mature and expectations shift. However from the evidence now, we believe it provides a good starting point for understanding where boards sit on the development spectrum and could be usefully adopted as part of a refreshed self assessment diagnostic alongside the questions attached as **Annex A** and in developing the Programme methodologies.

Moving beyond competence

Earlier in the report we identified that a desirable new feature of the Programme going forwards would be a focus on helping those boards which are ready to move beyond competence towards excellence. We also set out some practical considerations for doing this.

In the paragraphs above we identify some of the key steps the more progressive boards are now taking alongside a list of emerging attributes of a well performing board. Taken together, these findings offer some insight into how the Programme can identify those places ready for a deeper challenge and focus support on getting others to this place.

In addition, from our discussions we have been able to capture a sense of the sorts of issues these boards are now turning their minds to which we set out below. Once again this list is not exhaustive but offers a useful starter for ten in refreshing the Programme's offer here.

These issues include:

- A continued drive to sustain leadership, impetus and focus across the system including the need to be clear how the boards can continue to provide the leadership to deliver transformation at pace, focus on real action beyond strategy and develop a plan for doing so.
- Find ever improved ways of working which go beyond standard performance management processes. So, for example, some board chairs suggested they need to develop a better understanding and evidence base of what works and what does not and use this explcitly to inform decisions. Other suggestions include considering further opportunities to learn and work across geographical boundaries with neighbouring or like minded boards. A common theme in the peer challenges which is also relevant here is for boards to develop a proactive communications plan with a real resident focus.
- Start to drive solutions for the 'knotty' issues within the local system more proactively. Some of the suggested issues raised with us and evident within the peer challenges include influencing the future shape of primary care, developing a workforce plan for the future and focusing on people's behaviours and cultures to improve health outcomes.

5. Conclusions and future support

Last year we used get a grip, change gear, step up to the plate as phrases to encapsulate the challenges facing health and wellbeing boards as they shifted their focus from managing the transition to new arrangements to providing local system leadership for complex tasks such as health and social care integration and health service reconfiguration. This year we are suggesting '**Stick with it!**' encapsulates the frustrations at the slower than hoped for progress for many in tackling the big ticket items in relation to the future of health and social care alongside the successes of some, the cautious optimism of most for the boards' future and the well of goodwill to see them deliver to their full potential.

It is evident from this review that the boards remain on a spectrum of maturity and delivery and that some have made more progress than others. These boards too have challenges to face in moving beyond the strategising, but appear to have the belief, leadership standing and infrastructure in place to tackle this. Critically they seem to have the buy in and confidence of all board members and their constituent organisations to do so.

Those boards which are less advanced have made some progress across some common themes, notably relationship building. In addition the BCF has certainly galvanised progress. We highlight in this report the areas which still require attention but at the same time we have also been able to draw from the evidence emergingfeatures of a well performing board. These features are as much about behaviours and self awareness as they are about structures and processes.

This local context is important in thinking about the future of the support Programme and in ensuring that the appropriate support is available to ensure that local communities everywhere benefit from this localist approach to health and wellbeing.

Alongside this the national context is developing and changing and this will particularly be the case approaching the government election where uncertainty might well grow over what role and expectations will exist for the boards. All the signs are that the boards have support from across the political spectrum with the Conservative and Labour parties both committed to retaining them and the Labour party talking about 'reinvigorating them'. Despite this, stakeholders legitimately point out that this uncertainty and expectation will inevitably create a degree of 'churn' in the system which the Programme will need to help local systems navigate.

Earlier in this report we established that in its second year the Programme has been very responsive in adapting its priorities to meet demands in the system, informed both by stakeholder feedback and formal evaluations. In addtion the 'heavyweight' elements of the Programme – the peer challenges and the leadership essentials work – are generally very well received by those who participate in them. Feedback on the new leadership essentials course has been particularly supportive. The Programme has also been fleet of foot in introducing some in-year support to meet needs and demands as they have arisen eg the governance good practice guide and mentoring of local Healthwatch chairs.

Some issues have been raised relating to the peer challenge – the need to prioritise recommendations to ensure not overwhelming in number and to ensure in feedback the team is not pulling its punches. These issues, though raised by a minority, should be considered in any refresh thinking. In addition, there remains the more significant resource challenge to the peer process and we maintain a view that some shorter peer process could be considered to supplement, not replace, the bigger process. This would also extend to a wider audience the considerable system wide learning the peer challenges prompt. The LGA is developing its thinking here and refreshing the peer challenge methodology.

Our review has established that there are some key design features of the Programme which remain of critical importance or are growing in importance this year. These are ensuring systems wide learning and impact, retaining the capacity to be flexible and responsive and supporting boards beyond competence.

The coming together of the mapping of the system accelerators of progress, the evolving features of a well performing board and the developing sense of some of the issues the more advanced boards are turning their minds to offer an emerging picture of what beyond competence might look like to help inform the future activities and focus of the Programme. In discussions it became clear that any refresh of the methodology – notably but not solely that of the peer challenge – needs to incoporate these issues alongside consideration of the issues which still require attention.

Alongside this there is agreement that the Programme has yet to properly 'bite' on the issue of identifying, managing and supporting those who are in most need of assistance which remains a critical feature of the Programme. The LGA recognises this and has prompted further discussion here.

We drew the following conclusions from these discussions:

- The Programme should ensure there is a spread of resource, attention and capacity across the whole development spectrum of boards and not focus undue attention on one single group or area to ensure that all boards have access to some form of appropriate support.
- Having said that, the risk of those which are most in need of support needs to be appropriately managed.
- This means that there does need to be some legitimate targeting of those most in need of support – not just the minority with significant support needs but also those who are 'coasting' and whose progress risks stalling or slipping back.
- To do this well means capturing and using intelligence in a systematic way, focusing efforts on 'getting in the door' by developing an enhanced local improvement adviser role and ensuring clarity of what support is offered, and refreshing the self assessment and peer methodologies to include the areas requiring attention.
- Finally there are some views on the overarching aspects of the Programme which have emerged in discussions which are worth reinforcing in conclusion. These include:
- The need to consider the links between the other improvement programmes (from within and outside of the LGA) and to ensure there is cross fertilisation of learning and joining up where appropriate, while maintaining each individual programme's separate focus.
- For the health and wellbeing improvement programme this focus is on the developing and supporting the leadership in the system, with more technical or specific support coming from elsewhere.

- The organic, longer term approach of sector led improvement emphasised by some feels like an important design principle but it also needs to be considered alongside the need to have impact and with regard to national expectations.
- It is legitimate that the 'offer' is fluid but its key elements should be clear and the Programme's reach is likely to be enhanced by further clarity and effective promotion of it.
- The initial success of the Programme reaching beyond local government for eg to CCG and local Healthwatch members should be further explored as well as considering a deeper reach within local government itself, for example to the HWB coordinators.

If our message to health and wellbeing boards is 'Stick with it!' then our message to the Programme is the same!

Annex A
Questions for health and wellbeing boards to consider

Have you reviewed the fundamental purpose of your board and are its membership, sub-structures and ways of working fit for that purpose?

Is the board playing a leadership and oversight role in relation to the big issues, notably health and social care integration and the reconfiguration of health care services?

Do you need to improve engagement with key stakeholder who are not directly represented on the board, including: major providers, district councils and locality/neighbourhood structures?

Is there a need to streamline the partnership structures in your area?

Are you considering what action may be appropriate at a sub-regional level?

Are you using the evidence available to you in the most effective way to set priorities, drive change and monitor progress?

Are you giving due weight to qualitative evidence such as the personal stories of board members and the user, patient, carer and community voice?

Do all councillors and GPs in your area have a shared understanding of the communities they serve and their roles in meeting local needs?

Do you have a good understanding of the constraints and opportunities facing the major organisations in the health and social care system?

Is the board in control of its agenda and work programme?

Does the board have appropriate business and policy support?

Do you have an appropriate mix of formal and informal meetings?

Do you have the opportunity to think and reflect as a board and to explore questions such of those set out above?

Are you applying lessons from other major change processes in your area?

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